

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 169

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Fulton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Callaway
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution Two days
 In this community All of life
 years, months or days

3. (a) PRINT FULL NAME Andrew Leroy Jackson 257
 8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex Male 5. Color or race Black
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 11 11 1918
 (Month) (Day) (Year)

8. AGE: Years 21 Months 7 Days 21
 If less than one day _____ hr. _____ min.

9. Birthplace Callaway Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
 { 12. Name Kelly Jackson
 13. Birthplace Missouri
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Verna Baker
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Verna Vaughn
 (b) Address Fulton, Mo.

17. (a) Burial (b) Date thereof 7/3/1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Whitecloud

18. (a) Signature of funeral director Raymond Holt
 (b) Address New Bloomfield, Mo.

19. (a) July 23 1940 (b) R. N. Crews
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Callaway
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Near Carrington, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 2
 year 1940 hour 6 minute 25 P. M.

21. I hereby certify that I attended the deceased from June 27, 1940, to July 1, 1940;
 that I last saw him alive on July 1, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Uremia - Total Anuria - Duration 5 days
Thrombocytopenic Purpura 7 days
 Due to Acute nephritis ?
 Due to Strept. Sore Throat 10 days
 Other conditions (include pregnancy within 3 months of death) _____

Major findings:
 Of operations _____ 115°C
 Of autopsy _____
PHYSICIAN

 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature John I. Brown (M. D. or other) !
 Address Fulton, Mo. Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Ray A. Holt

Licensed Embalmer No. 2603

P. O. Address Beulah Bloomfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.